DEPARTMENT OF
INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES

# NOTICE OF DEATH FORM

**Within 4 hours** of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DIDD Regional Office Administrator of the Day or, if applicable, the DIDD ICF/ID Director or Chief Officer or designee by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/IID, send it to the DIDD Regional Director. If a developmental center, send it to the DIDD Facilities Administrator and to the Deputy Commissioner.

| **East DIDD Regional Director** | | **Middle DIDD Regional Director** | | **West DIDD Regional Director** | |
|---|---|---|---|---|---|
| Phone # | (865) 588-0508 | Phone # | (615) 231-5436 | Phone # | (901) 745-7361 |
| Fax # | (865) 594-5275 | Fax # | (615) 231-5350 | Fax # | (901) 745-7251 |
| AOD | (855) 828-4717 | AOD | (615) 218-0784 | AOD | (866) 925-4204 |

**PERSON SUPPORTED INFORMATION** **DIDD REGION**: [ ] East [ ] Middle [ ] West

**NAME**: _____ **DATE OF BIRTH**: _____

**SOCIAL SECURITY NO**: _____ **AGE AT DEATH**: _____

**RACE**: [ ] White [ ] Black [ ] Hispanic [ ] Other **SEX**: [ ] Male [ ] Female

**CLASS MEMBER STATUS**: [ ] Settlement Agreement [ ] Not applicable

**FUNDING STATUS** [ ] "Statewide" Waiver [ ] "Self-Determination" Waiver [ ] Private ICF/IID

[ ] CAC Waiver [ ] State-Funded [ ] Developmental Center [ ] State ICF/IID

**RESIDENCE**

[ ] Lived with family [ ] Supportive Living [ ] Private ICF/IID

[ ] Lived in Own Home with Support [ ] Residential Habilitation [ ] Developmental Center

[ ] Lived Independently [ ] Medical Residential Services [ ] Nursing Facility

[ ] Family Model Residential Services [ ] Other (explain) _____

**DID THE PERSON SERVED MOVE IN THE PAST 6 MONTHS?** [ ] No [ ] Yes (specify date: _____)

**DATE OF DEATH**: _____ **DATE REPORTED**: _____ **TIME REPORTED**: _____ AM / PM

**PLACE OF DEATH** [ ] Home [ ] Psychiatric Facility

[ ] Hospital [ ] Other (explain) _____

**DETAILS OF DEATH** _____

**1. AUTOPSY REQUESTED?** [ ] No [ ] Yes, If so, by whom _____

**2. MEDICAL EXAMINER CONTACTED?** [ ] No [ ] Yes, If so, by whom _____

**3. CORONER CONTACTED?** [ ] No [ ] Yes, If so, by whom _____

**4. INCIDENT FORM SUBMITTED?** [ ] No [ ] Yes

**INDICATE WHO HAS BEEN NOTIFIED**

[ ] ISC/Case Manager [ ] Legal Representative [ ] Family [ ] DIDD Investigator [ ] Police

**NAME OF PRIMARY CARE PROVIDER**: _____ **PHONE NO**: _____

**TYPE OF CASE MANAGER** [ ] ISC [ ] State Case Manager [ ] QMRP

**NAME OF CASE MANAGER**: _____ **PHONE NO**: _____

**NAME OF ISC AGENCY**: _____ **PHONE NO**: _____

**NEXT OF KIN** and/or **LEGAL REPRESENTATIVE**: _____

**GENERAL HEALTHCARE INFORMATION**

**NAME OF PERSON SUPPORTED:** _____

**AMBULATION:** [ ] Ambulatory [ ] Non-Ambulatory

**COMMUNICATION:** [ ] Verbal [ ] Non-verbal

**NUTRITION:** [ ] Eats Independently [ ] Eats w/ Assistance [ ] Tube fed

**WEIGHT IS:** [ ] Normal Weight [ ] Overweight [ ] Underweight

**WEIGHT:** _____ **HEIGHT:** _____

**PHYSICAL STATUS REVIEW** (if applicable) **DATE OF LAST PSR:** _____ **PSR LEVEL:** _____

**MEDICATIONS:** _____

**INTELLECTUAL DISABILITY** [ ] Mild [ ] Moderate [ ] Severe [ ] Profound [ ] Unknown / Unspecified

**Etiology** (if known): _____

**BEHAVIORAL / PSYCHIATRIC DIAGNOSES:** _____

**GENERAL MEDIACAL DIAGNOSES:** _____

**HOSPITALIZATIONS / PROCEDURES** (over the past 12 months)

| Reason for Hospitalization / Procedure: | Treatment Location: | Date: |
|---|---|---|
| | | |
| | | |
| | | |

**Name of Provider, Private ICF/IID, or DIDD Developmental Center** **Phone Number**

**Person Completing this Form** (please print) **Title**

**Signature** **Date**